



Medical History Form

Today's Date: _____ Name: _____ Date of Birth: _____

Do You Think of Yourself as (circle): Heterosexual Homosexual Bisexual Something Else Unsure

Last Menstrual Period: _____ Any Irregular Bleeding: Yes No

Has Your Uterus Been Remove: Yes No If Yes, For What Reason: _____

Do You Still Have Ovaries: Yes No Are You On Hormone Replacement Therapy: Yes No

Allergies to Medications, Environment, or Dyes (Please Include the Reaction to All Allergies):

Medications:

What Are You Using For Birth Control: _____

Did You Receive Gardasil (HPV vaccination): Yes No

Medical History: (Please Circle Any That Apply to YOUR Health):

- | | | | | |
|-----------------|----------------|---------------------|--------------------------|------------------|
| Alcoholism | Arthritis | Asthma | Blood Clot/DVT/PE | Cancer |
| Chlamydia | Depression | DES Exposure | Diabetes | Drug Addiction |
| Eating Disorder | Genital Warts | Gonorrhea | Headaches/Migraines | Heart Disease |
| Hepatitis | Herpes | High Blood Pressure | | High Cholesterol |
| HIV | Kidney Disease | Lupus | Mental Health Conditions | |
| Osteoporosis | Seizures | Syphilis | Stroke | Thyroid Disease |

If You Circled YES To Any Of The Above, Please Explain:

Surgical History: (Please Indicate Type and Date):

Family History: (Please Note The Family Member & Maternal (M) OR Paternal (P) When Appropriate):

Breast Cancer: _____ Colon Cancer: _____
 Diabetes: _____ Genetic Disorders: _____
 Heart Disease: _____ High Blood Pressure: _____
 Kidney Disease: _____ Lung Cancer: _____
 Osteoporosis: _____ Other Cancer: _____
 Ovarian Cancer: _____ Ovarian Cancer: _____
 Stroke/DVT/Clotting/Bleeding Disorder: _____
 Thyroid Disease: _____ Uterine Cancer: _____
 Other: _____

Note The Date For The Following Tests, If Applicable:

Mammogram: _____
 Colonoscopy: _____
 Bone Density Scan: _____

Pregnancy History:

Check If No Changes

Total Number of Pregnancies: _____
 How Many Living Children: _____
 Miscarriages: _____
 Abortions: _____
 Preterm Delivery: Yes No
 Any Cesarean Sections: Yes No
 Any Complications with Pregnancies: Yes No

Social History:

Do You Smoke: Yes No If Yes, Amount: _____
 Do You Drink Alcohol: Yes No If Yes, Amount: _____
 Any Drug Use: Yes No If Yes, Type & Amount: _____
 Do You Have Any History of Abuse: Yes No If Yes, Type, Age, & By Whom: _____